COAST GUARD SPECIAL NEEDS ENROLLMENT AND ASSESSMENT FORM

Instructions: Complete the following three pages and submit, along with supporting documentation, to your Family Resource Specialist or Family Advocacy Specialist at your Work Life Office.

DATE_____

SPONSOR'S NAME_____ SSN#_____

RATE _____ DISTRICT _____ UNIT_____

WORK TEL. # _____ HOME TEL. # _____

HOME ADDRESS _____
(Include zip code)

NAME OF CHILD/SPOUSE WITH SPECIAL NEEDS _____

DATE OF BIRTH OF CHILD/SPOUSE _____

TYPE OF DIAGNOSED SPECIAL NEEDS CONDITION (Hearing, Vision or Speech Impaired; Cerebral Palsy; Mental Retardation; Attention Deficit Disorder; Down's Syndrome; Spina Bifida; Seizure Disorder; Learning Disabilities; Developmental Delays; Emotionally Disturbed; Hydrocephalus; Chronic illnesses such as heart, kidney, cancer, asthma, blood disorders, tumors; Depression; Head or Spinal Cord Injuries; etc.)

CAUSE OF SPECIAL NEED (if known):

TYPES OF THERAPY/TREATMENT NEEDED OR CURRENTLY RECEIVING (Speech; Physical Therapy; Occupational Therapy; Psychotherapy; Chemotherapy; Radiation; Specific Medications; Medical Specialists; etc.):
SPECIAL SCHOOLS AND/OR PROGRAMS ATTENDED: (Infant Stimulation; Center Base School; Home Resources; Residential Treatment Facility, Learning Disabled Classes; Resource Room; Special Education Classes; Chemical Substance Program; etc.):

SPECIAL EQUIPMENT NEEDED: (Wheelchair; neck, arm, leg and/or back braces; crutches, apnea monitor; hearing aids; glasses; modified car or van; feeding devices; communication board (Bliss); etc.):

SUPPORT GROUPS USED, IF ANY: (Parents of Down's Syndrome Children; Parent Groups Within Schools; Parents of Learning Disabled Children; National Parent Network on Disabilities; Easter Seals; National Cancer Society; Candlelighters; etc.):

SPECIAL PROBLEMS AND/OR CONCERNS: (Availability of Special Schools and/or Programs; Lack of Medical Specialists/Therapists, Medications and Equipment; Support Groups, etc.):

NAME OF FAMILY ADVOCACY SPECIALIST (FAS) AND TELEPHONE NUMBER:

Ms. Alicia Lucero-Wagner, FAS (510/437-3068)
Mr. Alan Wilson, FAS (510) 437-3927

NAME OF UNIT FAMILY ADVOCACY REPRESENTATIVE (FAR) AND TELEPHONE NUMBER:
Same as above

HAS A COPY OF THIS ENROLLMENT FORM AND SUPPORTIVE DOCUMENTATION BEEN SENT TO YOUR FPA OR DRC?

DO NOT E-MAIL OR FAX THIS FORM. PLEASE SEND THIS FORM TO THE ADDRESS BELOW.

UNITED STATES COAST GUARD
WORK-LIFE STAFF
BUILDING 16 ROOM 107

ATTN: Family Resource Specialist
Kristine Cooper 510 437-5378

YES _____ DATE _____ NO _____

HAS A COPY OF THIS ENROLLMENT FORM AND SUPPORTIVE DOCUMENTATION BEEN SENT TO HEADQUARTERS (G-PWL-2)

YES _____ DATE _____ NO _____

ESTIMATED DATE/YEAR OF REASSIGNMENT: _____

Documentation of Special Need

SPONSOR AUTHORIZATION: I, _____ hereby authorize the release of medical, psychological, psycho-social, social services, legal, educational, law enforcement, and other pertinent information to the Family Resource Specialist.

Mail completed form to: **United States Coast Guard**
Work-Life Building 16 Rm 107
Coast Guard Island
Alameda, CA 94501

Name of Treating Professional_____
Address_____
Phone Number_____

Date of Report or Evaluation_____

Patient's Name_____ DOB_____

Coast Guard Sponsor's Name_____

Patient's
Diagnosis:_____
_____
_____

Patient's
Prognosis:_____
_____
_____

Patient's Treatment
Plan:_____
_____
_____

_____ _____
Signature of Treating Professional Date

_____